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PRURITUS HIEMALIS—AN UNDESCRIBED FORM OF PRURITUS.

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IN the present paper I wish to describe and direct attention to a certain affection or condition of the skin of which there is no mention in any of our treatises upon cutaneous diseases or elsewhere. Quite a number of examples have been brought to my notice within the last few years; in some instances the trouble being of such severity as to call for careful investigation and subsequent treatment. Moreover, the affection about to be described has never, so far as I am aware, been separated from several other conditions of a similar nature with which it has heretofore been grouped. But the symptoms, course, and cause of the disorder appear to me to be so clearly defined as to merit a distinct and separate consideration.

The trouble varies much in degree, at one time being of the most serious inconvenience to the patient, and at other times being of so mild a character that medical advice is not sought. Thus, it may be so slight as scarcely to deserve the name disease, or, on the other hand, so severe that the individual is rendered most miserable by it. When of a mild type, for reasons presently to be mentioned, the patient endures the condition without undergoing treatment, for experience has taught him that the condition is a temporary one, and will, in due time, subside spontaneously. Previous attacks have taught him that sooner or later, in the course of a few weeks or longer, his skin will again be in a normal state, and this occurrence of the change to health is anxiously looked for. The skin sooner or later rights itself without treatment, and the patient remains free for a certain period. But, on the other hand, it may occasion such discomfort and distress that the person anxiously consults his physician, and willingly submits to any treatment, with a view of obtaining at least temporary relief. The symptoms may be so annoying and disagreeable as to render existence most unhappy for the time being. For the reason, then, that it is a trouble by no means rare, as well as one frequently requiring attention from the physician, I shall offer the result of my observations. I have designated the affection *Pruritus Hiemalis*, for reasons which I think will appear satisfactory.

Symptoms.—The affection consists in a peculiar state of irritability of the skin, which manifests itself in the autumn or even as late as the winter season. Generally it first makes its appearance with the advent of our cool October weather, or at about the time of frost. It may, however, not be noticed until later in the season—as late as

December. In Philadelphia it commonly occurs towards the latter part of October, and continues usually until the cold weather has been thoroughly established, or even through the winter. Its duration is variable. In some cases it lasts but for a few days or weeks, and then disappears entirely. In other instances it remains present persistently for several months or longer; but it is never present after the cold weather has passed. With spring it always vanishes, to be absent at least until the succeeding autumn. It is rare, however, to observe it continuing in any marked degree through the entire winter. It is an affection of the cool weather only, and more particularly of the fall and winter season. It is never present in the summer months. It is found upon individuals of all ages, from childhood to old age. No particular period of life appears to be more susceptible than another. I have never met with it in young children, nor indeed much before the age of puberty. It occurs in both sexes in about the same proportion. It may exist upon any part of the body, though prone to attack certain regions in an almost invariable manner. It is confined, not entirely, but to a great extent, to the lower extremities, and it is here that it shows itself typically. It occasionally is found upon the arms, and more rarely upon the trunk, but never to the same extent and degree as upon the thighs, buttocks, and legs. The hands, feet, face, and scalp are never involved. Its common seat is upon the inner surface of the thighs, about the knees, in the popliteal space, upon the calves of the legs, and around the ankles. It affects the non-hairy portions of the limbs rather than the hairy parts. The outer surface of the thigh and the region of the tibia are more rarely involved than, for example, the calf of the leg. The calves of the legs are favorite localities for the trouble. It attacks both lower extremities symmetrically. Occasionally only the ankles and calves are affected, but in most cases it extends well up upon the thigh. It is not a localized affection,—that is, cannot be said to exist upon any given portion of the body exclusively. The sensation may be most intense here or there, as the case may be, or it may move from time to time from one locality to another. But the same regions are usually attacked day after day, and the symptoms remain there until they disappear entirely; and hence, although it cannot be said to be localized, yet, if present at all, it is almost invariably to be found upon the regions which I have particularized.

The affection may be said to be characterized by a certain itching of the skin, more especially of the lower extremities, which comes upon the individual rather suddenly, in the course of a few days, during the autumn or early winter, and which may be described as an itching, smarting, tingling, burning sensation, as though the person were clothed in new flannel or woollen-wear, and the same were rubbing and chafing the skin. The amount of irritation present varies with different cases, and may be either very slight, so as barely to attract attention, or it may be so severe and troublesome as to cause the sufferer very great annoyance and distress. It

possesses one peculiarity which is striking, and generally present,—namely, the tendency to become aggravated towards night. It is always worse in the evening than at any other period in the twenty-four hours, and in many cases is present only at this time. In the mild form it is scarcely noticeable during the day, coming on with evening, and continuing through the night until sooner or later the patient retires and falls asleep. It is when taking off the clothes, at night especially, that the itching is most noticeable and severe. At this time the desire to scratch and rub the affected parts is almost irresistible, and the person usually gratifies this desire either until some relief is obtained or sleep terminates the suffering. A certain amount of relief follows severe scratching, and a marked burning sensation takes the place of the itching, which is far more grateful to the feelings of the patient. According to the amount of disturbance and the irritability of the cutaneous nerves, will the sleep be more or less interfered with. At times the skin is so excited and disturbed that the person obtains but imperfect rest, and at least the earlier part of the night is passed in scratching and in making cooling applications of one kind or another to the parts. In other cases the itching is simply unpleasant and annoying upon retiring, but not sufficiently so to interfere with sleep.

Upon awaking in the morning, a little of the pruritus may still exist, but usually it has quite subsided, and no further thought is given the subject until the following evening, when the same symptoms reappear, and are exactly repeated. In this manner it continues day after day, with but slight intermission, until, at the end of an indefinite period, it gradually vanishes. The patient now remains free of it until the next autumn, when in all probability it will recur and run a similar course. It may relapse in this way year after year, or at the end of the first attack it may disappear, not to return. It is apt, however, to attack the same individual several seasons in succession, and then remain away permanently. It may also continue through a lifetime.

There is no *primary* eruption of any kind connected with the affection, either at its commencement or at any time during its course. This is an important point to be remembered in connection with the diagnosis. If the skin be minutely and carefully examined at the beginning of an attack, we see nothing indicative of disease, or anything, indeed, which would enable one to account for the itching present. Inasmuch as the condition is always most marked and typical about the lower extremities, I shall describe the appearance of the skin as seen in a well-defined case the first day of its existence, for later the appearances are quite different, and call for a separate description. When the trouble is first noticed, then, the skin looks quite healthy, with the exception that it is apt to be somewhat dry. The epidermis seems normal, and there is no desquamation. The skin is neither hot nor hyperæmic. The hair-follicles are neither inflamed nor obstructed, and appear to be in order. There is no accumulation of epidermis or other matter about

their openings. They are not prominent nor visibly altered. In fact, after close inspection, it is impossible to distinguish any sign of derangement in connection with the follicles, which parts, upon first thought, we might imagine to be the seat of the disorder. Here and there an inflamed follicle may exist, but this condition, however, occurs only occasionally at this stage of the trouble.

The condition of the sudoriferous glands it is difficult to determine, further than that they do not work very actively; but there is no reason for supposing that they are in any serious way deranged, or more so upon these localities than upon other portions of the body. There is no perceptible functional derangement of the skin. Neither is there any organic alteration observable. The subjective symptoms, which the patient communicates, alone convey any idea of the condition.

But if the case be seen several days or longer after the first symptoms, the skin looks different. Certain secondary changes now exist which, if error is to be avoided, must be viewed as such. For to regard these *secondary* lesions, which at this stage are present, as the *primary* lesions of the affection, would certainly be misleading as to the nature of the disorder. It must be remembered, too, that this stage is the one in which cases are usually seen, for advice from the physician is rarely sought before the trouble has existed for some time.

The skin now may be rough and harsh, resembling xeroderma or mild ichthyosis. Many of the hair-follicles are red and more or less inflamed and irritated, with an accumulation of epidermis and sebaceous matter about their openings. Many of the hairs are also torn and broken off short, close to their follicles. Here and there, or over a considerable surface, the whole skin looks red and irritated, as though it had been well rubbed and scratched. Upon close inspection, the epidermis bears unmistakable evidence of having been torn and wounded. The marks of the finger-nails are everywhere to be seen, often in the form of long streaks up and down the limbs. In fact, all the phenomena just detailed, which are so marked and prominent, are produced solely by the hands of the patient. They are all *secondary* lesions. They are the *results* of the pruritus. To view them as the primary lesions would give a very wrong idea concerning the nature of the trouble. The line of distinction between the primary and the secondary symptoms must be clearly drawn. The primary symptoms are subjective alone. The secondary symptoms, those usually seen clinically, are both subjective and objective, the latter being an artificial product, caused by external irritants.

Such is a description of the disorder as I have encountered it through a number of seasons, and which it has been my pleasure to study and note as opportunity for observation upon new cases offered. There are other points of interest to be mentioned, which it will be more convenient to consider under the various heads of Etiology, Diagnosis, and Treatment.

Etiology.—In turning our attention to the cause of this trouble, there are a number of facts which I

have observed and noted, and which now present themselves for consideration. From these alone we shall be obliged to draw our conclusions, be they satisfactory or not, for they constitute our only aid and guide in endeavoring to ascertain the cause. One important observation, which has been universally noted, determines the fact that the condition is intimately associated with atmospheric changes. It is emphatically an affection of the cold weather, at the commencement of which it invariably establishes itself. With the first decided and permanent change of the fall season, with the first ice, it is usual to note its presence.

Now, this fact is observed not in one, but in all cases. And here it must be remembered that the observations which I am about to detail refer exclusively to the latitude and climate of Philadelphia. What the conditions may be a thousand miles north or south of this point, I am not prepared at present to state definitely; but, from memoranda in my possession,* the affection also manifests itself very commonly in more northern latitudes. In southern countries it is unquestionably more rare, if indeed it occurs at all. But upon this point I have no reliable data. In England, inasmuch as no writer upon the subject of diseases and affections of the skin has referred to the condition, we are warranted in assuming that it is very rare. As a student of dermatology I passed several months of the autumn and winter season in London, attending daily large clinics of cutaneous diseases; but I do not recall ever having encountered any cases of the trouble, notwithstanding every variety of disease and alteration of the skin presented itself. The works of English writers upon dermatology do not so much as allude to its occurrence. My experience in France and Southern Germany, especially in Vienna, extending over a period of a whole autumn and winter season at the two largest daily clinics for diseases of the skin in the world, was similar to that in London, the condition never having been noticed. Nor do the German writers mention its existence in their treatises upon cutaneous disorders. But to return.

It occurs in persons otherwise in excellent health. The various other functions of the economy appear to be in perfect order. The nervous system, so far as can be ascertained by symptoms, shows no signs of general impairment or derangement. The bowels are not constipated, nor are any of the secretions apparently abnormal.

The affection is found upon people of all ages, and is not common to any particular period of life. It is observed upon the young as well as the old. As already stated, it occurs in both males and females. At times it is seen in several members of the same family. It is found equally among those who live in luxury and comfort, and those dwelling in poverty. It occurs among the black race. It is as common in the houses of the wealthy as it is in our almshouse. No class of society is exempt. It is not a condition caused, or in any way influ-

enced, by neglect of person or by inattention to cleanliness, for it exists in no greater proportion among the dirty and unwashed than among the clean. It is as frequent among bathers as among those who never use the bath. It is present both among those who bathe in cold and those who bathe in warm water. It is as common among those who employ the bath every day as among those who use it more seldom. From these facts it will be noticed that water possesses very little influence in either its prevention or its causation.

Here it will be in place to refer to a series of investigations which I have made during the past month (December). Feeling assured from previous experience that the condition was in all probability to be found among all classes of a community, I was induced to examine a large number of people. My investigations were undertaken with a view of ascertaining to what extent the disease existed; also, if examples were found, for the purpose of studying them and corroborating previous observations. The results of my labors may be summarily stated as follows:

The wards of the Philadelphia Hospital (Blockley) and the Almshouse were selected for the purpose.† Both sexes, all ages, as well the cleanly as the uncleanly in personal habits, were included. Four hundred and twelve persons were examined. Of this number two hundred and twenty-seven were men, and one hundred and eighty-five were women. They consisted of cases from the hospital who neither had been nor were confined to bed, and also paupers from the almshouse.

Out of the whole number, four hundred and twelve, twenty-two cases of the disease were found. Fourteen were among the men, and eight among the women. Each of these cases was carefully examined, and the diagnosis fully established. Some of them were slight, while others were more severe; but there was no difficulty in recognizing the trouble in any of the cases. None of them, however, were of such severity as several of the cases which have come under my notice in private practice. Among the patients examined there were examples of pruritus whose exact nature seemed somewhat doubtful; these were excluded.

From these figures it will be seen that upon an average the condition exists in one out of every twenty persons who are otherwise in ordinary health. Whether this ratio holds good among the upper classes, who are better cared for and nourished, we have no means of determining positively at present, but there is every reason to think that it exists quite as frequently.

The disease is not caused by any peculiarity in the clothes worn. This is a point about which I desire to speak more at length, for there exists an impression in the minds of some that the condition I have been describing is simply an irritation of the hair-follicles and skin, due alone to the coarse, irritating undergarments usually assumed at this season of the year. Flannel and woollen goods, especially,

* I am indebted to Dr. Wigglesworth, of Boston, for certain notes relating to the affection as there noticed by him.

† My thanks are due to Dr. Linn, Resident Physician to the hospital, for the many facilities received in pursuing the investigation.

have been cited as being among the direct causes of this pruritus. But investigation and accurate observation, I think, will prove the error of this idea, which has obtained credence with some. Patients themselves at first are likely to attribute it to such causes, but subsequent experience proves even to them that such is not the case.

Now, neither flannel, woollen-wear, nor rough goods of any description, are the direct causes of this form of pruritus, but when they are worn they always tend greatly to aggravate the condition. In fact, not only do such garments increase the itching, but patients find it intolerable to use these fabrics, on account of the irritation which they provoke. The skin is so excited that such goods are unbearable, and the patient soon learns to shun them once and forever. Clothing, whether new or old, whether of wool or of cotton, then, is not the primary cause. For here also clinical experience proves that the affection exists upon persons who have never worn woollen or other rough undergarments of any kind. It occurs in those who are most careful in avoiding harsh irritating underclothes, and also in those who wear only the finest linen next to the skin.

External irritation, therefore, has no share in the primary cause.

Diagnosis.—We come now to speak of the diagnosis; and here I must state that the trouble we are considering has manifestly been confounded with other conditions of a similar character. It is by no means a rare disorder. It is to be seen every season, at our clinics for diseases of the skin, but it has been associated and confused with other diseases to such an extent that its individuality has been lost. The fact, moreover, that it may occur in so many grades of severity, from the mild to the most aggravated type, has tended to render its true character somewhat obscure.

The affection primarily is a pruritus of the skin. By the word pruritus I mean a functional disorder of the skin unattended by an eruption or breaking-out, and whose only symptom is itching and other like sensations. In the trouble we are discussing, then, there is no rash or change of any kind in the texture of the skin. The symptoms are simply itching, burning, and smarting of the skin, unaccompanied by any visible cause. Such is the primary condition of the disease. The secondary stage shows us these same symptoms present, and, in addition, other signs which must be here referred to. With the advent of the pruritus the patient at once begins to scratch, the desire being so strong that it is not to be resisted. The rubbing and scratching are often inordinate, and this process continued night after night, for perhaps several hours at a time, necessarily irritates the skin. The epidermis and hair-follicles suffer first, and about the openings of the latter a slight congestion is soon induced, which is kept up by the constant renewal of the cause. The hairs are broken off, twisted, and torn by the violent scratching and rubbing. Many of them are completely destroyed, and usually in a short time certain parts of the limbs are entirely devoid of hairs.

The follicles likewise are often obliterated, leaving a smooth, bald surface, which remains. The appearances at this stage may be manifold. The skin may be harsh, dry, and rough; or it may be smooth and natural. This varies according to the general condition of the skin. Frequently a certain amount of desquamation is present, covering parts of the limb as fine detached bits of epidermis. Scratch-marks can almost always be seen now if looked for, and generally they are noticeable even upon a casual view. Often they are observed as long streaks showing the tracks of the finger-nails. Signs of blood are more rare. Here and there, however, torn and lacerated follicles are seen, some of which may show a small quantity of fresh or dried blood. In some cases congested follicles appear in numbers; they are red, and appear acutely deranged. They may be somewhat obstructed with epithelium and epidermis, or they may assume the look of little elevated points. The intervening skin is generally more or less red and irritable. In other cases, in place of these symptoms nothing abnormal is to be seen, the scratching having little effect in producing artificial lesions.

All these visible symptoms, then, must be considered as artificial, as caused by the operations of the patient in the endeavor to get relief. They subside rapidly upon the cessation of the scratching or other mechanical irritation, whatever it may be, and are soon lost sight of, remaining away until irritation causes them again to appear.

There are two diseases with which pruritus hiemalis may be confounded. I refer to lichen pilaris, and prurigo as understood in this country.

Without entering into any differential diagnosis, I shall point out, in as few words as possible, wherein pruritus hiemalis differs from the two conditions just enumerated. The lichen pilaris of authors, as the name indicates, is a certain disease involving the hair-follicles of the skin alone. As described by several writers of the present day, it consists in an accumulation of epidermis and sebaceous matter about the openings of the follicles. This state of disease is the primary and only one. Itching may or may not be present; frequently it is absent. Lichen pilaris is commonly seen upon those who do not bathe, the masses of epidermic product being permitted to remain about the hairs, where, by degrees, a slight conical elevation or papule is formed, the hair or its stump perforating the centre of the accumulation. The affection is usually located upon the thigh, and especially the outer surface, where it is, as a rule, the most marked. Other parts of the body may also be affected in like manner. It is a condition speedily relieved in the majority of instances by the free use of hot baths and soap, which, by mechanically removing the obstruction of the follicles, permits these organs again to assume normal action.

From these few general points it is plain that there can exist no connection between lichen pilaris and the pruritus which I have attempted to describe. It will, I think, be seen that they are totally different conditions, having in reality little or nothing in common excepting that they are apt to occur at

about the same time of year; but other affections of the skin are likewise prone to show themselves in the fall and winter, and this, therefore, must be regarded merely as coincidence.

Lichen pilaris has its favorite seat about the outer surface of the thighs. Pruritus hiemalis occurs anywhere upon the limbs, with predilection for the less hairy parts. Lichen pilaris never occurs in the popliteal space. This is one of the common localities in which to find pruritus hiemalis. Many other differences there are, which will be noticed by comparing the symptoms of the two disorders side by side. I dwell upon this subject, because it has long since occurred to me that the pruritus we are discussing, particularly the secondary stage, has been associated with lichen pilaris. In many instances this undoubtedly has been the case.

With *true* prurigo, the prurigo of Hebra, we have the formation of distinct plastic papules: hence this pathological lesion alone is sufficient to distinguish the two affections.

Itching, scratching, excoriations of the skin, and other like symptoms due to the presence of pediculi, are here referred to merely for the purpose of mentioning that they have no share whatever in the pruritus we are discussing. They may possibly exist coincidentally at times, just as pediculi are liable to be found upon any person, but they are never the cause of the disease. No more need we even suspect the presence of any of the vegetable parasites as a cause.

Pruritus, or itching of the skin, is a term under which are included many varieties. The word pruritus, used alone, simply informs us that there is an itching of the skin, but fails to state the nature or cause of this sensation. Pruritus may be produced by many causes, due to derangement or disorder of one kind or another in the cutaneous surface. This subject interests us here only to the extent that we may be able to distinguish the variety which we have designated "*hiemalis*" from the many other kinds which are encountered.

Once recognizing the trouble as a pruritus, it seems as though there could be little danger of confusing it with any of the other forms. When all the symptoms are taken into consideration, there really exists no other variety which runs a like course with similar symptoms. The fact of its being an affection of the fall and winter season only, stamps its individuality at once. Its almost exclusive habitat—the lower extremities—is another peculiarity which it is important to remember. The particular parts of the limbs almost invariably involved also must be borne in mind. The almost entire freedom during the day, and the constant attack towards night, and especially upon the taking off of the clothes, are also characteristic.

Treatment.—With reference to the treatment of this form of pruritus, my experience has been confined to some twelve or more cases which have from time to time been under my care; about half being in private practice and the remainder in dispensary practice. I shall briefly give the results of the various remedies employed. First, as to water.

Plain water-baths, whether hot or cold, do not appear to exert much permanent influence over it, but, of the two, hot water more often affords some relief. The cold douche to the parts frequently gives temporary ease, and allows the patient an opportunity of getting asleep. A course of continuous daily bathing in cold water, kept up for the season, does not seem to exert any favorable influence. A warm bath daily, however, upon going to bed, will often insure the patient more comfort. Turkish baths have been employed, but with no success in relieving the symptoms. A course of thorough soaping with soda-soap, and afterwards a warm plain bath, has also been used, but with no better result than the simple bath. Where the scratching and other secondary lesions are marked, this course of treatment is not to be recommended, for, the skin being wounded, the soap together with the friction only increases the already irritable skin. Better success, however, may be found in the use of the alkaline bath, which affords more permanent relief than any other treatment with which we are familiar. The bath is prepared by dissolving four ounces of the carbonate of soda in a full-sized bath-tub of warm water. The water should be sufficiently hot to allow the patient to remain in it without feeling at all chilly. The patient should stay quietly immersed in the water for twenty minutes. Upon getting out of the bath the parts should be slowly and gently dried by patting with a soft dry towel. No rubbing or friction should be indulged in, for, though gratifying at the moment, the after-effects show the skin to have been greatly excited and the trouble aggravated.

The bath should be taken in the evening, just before retiring. The patient should wear a light night-dress, and sleep as coolly as possible; the bed should be hard,—preferably a mattress,—and the covering just sufficiently warm to prevent a feeling of chilliness. The sheets should be of soft muslin or linen.

During the daytime, linen, muslin, or the so-called Canton flannel underclothes should be worn, and all garments of a woolly nature discarded. Everything must be done to soothe the irritable skin in all possible ways. Heated rooms and hot stoves must be avoided. During the evening a walk in the cool air will be much more grateful than the warm room; for if the itching be inordinate in a hot, dry atmosphere, and the patient suddenly go into the open air, it will be found that the symptoms will to a great extent subside. As is well known, these remarks apply to almost all forms of pruritus, but they are especially applicable to the kind I am describing.

As with other varieties of pruritus, simple rubbing, or scratching with the finger-nails, unless it be excessive, does not produce any great amount of laceration of the skin. The patient may scratch quite severely at night, and yet, upon awaking, find very little trace of the performance. This remark supposes the case to be a mild one. If the case be severe, the scratching will necessarily be violent, and the skin will then show signs of the destructive work which has been done.

With reference to internal treatment I have little to suggest, for, though preparations of iron and arsenic have been employed in certain cases, unfortunately there is nothing favorable to report.

From what has been said, it will be evident that the affection must be regarded as a pruritus. The symptoms from which we are forced to deduce our conclusions are purely subjective, and hence, unless we venture into the domain of theory, our remarks concerning the pathology must soon come to a termination.

In the present state of our knowledge very little is positively known concerning the nature and pathology of neuroses. In the condition described, further than that it is a pruritus of a certain kind, accompanied by a series of well-marked and constant symptoms, our information does not permit us to go. What changes take place in the skin in order to give rise to these symptoms, it is impossible to ascertain. An irritability of the skin, taken as a whole, unquestionably exists, but in what particular organs or parts the derangement occurs it is not possible at present to determine. To suggest that the disease has its origin and is located about the follicles, and that all the symptoms may be referable to derangement of these organs, is a theory attractive and perhaps plausible, but in the present state of our knowledge more definite information is required before adopting this view.

In brief, to venture further in theory as to the exact nature of our trouble is not consistent with the tenor of this communication. Positive knowledge upon such points relating to anatomical and pathological changes is alone desirable, if we would advance our subject in a scientific manner.

ACCIDENTAL HEMORRHAGE DURING PREGNANCY.

BY H. LEAMAN, M.D.

ACCIDENTAL hemorrhage, occurring during pregnancy and preceding labor, embraces all hemorrhage which may take place from accident of any kind, excluding placenta prævia or unavoidable hemorrhage, as well as all effusions of blood which may occur of a vicarious character in other tissues and organs.

It has its seat in the vascular system of the uterus or in that of the fetus. It may occur early in pregnancy, in the form of effusion from the general uterine surface; later, the hemorrhage is most commonly due to a separation of the placenta from its uterine attachment, or to a rupture of the umbilical cord. Effusions are due to an increased flow of blood to the organ, which begins with conception. The separation of the placenta may be brought about by mechanical violence, and by vascular or nervous derangement. A rupture of the cord may be due to a shortness, an irregular distribution of the vessels, or a degeneration of the envelope of the umbilical vessels.

The hemorrhage may be open, the blood finding its way between the membranes and uterus, and

appearing externally. In concealed hemorrhage the blood may be retained beneath the placenta and within its circle of attachment; it may be retained between the membranes and the wall of the uterus; or poured into the amniotic cavity,—intra-amniotic.

Dr. Meadows gives the statistics of Dr. Churchill, as follows: in 257 cases of accidental hemorrhage 34 proved fatal, or one in seven; while of 292 cases of unavoidable hemorrhage 79 proved fatal, or one in three and a half; and out of 365 cases of post-partum hemorrhage 25 proved fatal, or about one in fourteen.

Cazeaux says that hemorrhage occurring early in gestation is more serious to the child; in the latter part, to the mother; especially dangerous to the mother between the seventh and eighth months. That the life of the mother is in little danger in the early months of gestation seems to me to be sustained by experience, as well as by the very common practice in our day of interfering with the product of conception either by drugs or instruments. One case came under my notice in which the woman was suffering a severe hemorrhage, from which she readily recovered. She confessed that it had been brought on by the use of an instrument in her own hand, and that it was the seventh time she had succeeded. She showed us an old well-worn Simpson's sound. Very recently a similar case has come under my notice, and such cases, I believe, are not new. When death does result from these cases it is generally due to a typhoid or inflammatory condition. Hemorrhage occurring within the last three months, however, is an entirely different thing. How to act under these circumstances, when two lives are hanging by very tender threads, and when we may be the means of cutting one or both, requires all the wisdom we can command, as well as the inspiration of an Hippocrates. To illustrate my subject, it seems preferable to give the narration of a case which came under my care in the early part of the past spring.

Mrs. Anna McBride, aged 32 years, the mother of six healthy children, pregnant with her seventh, was taken with a slight hemorrhage between the fifth and sixth months of gestation,—February 21, 1873. Two or three days' rest relieved her entirely, and she went about her household duties as usual. These were not of the lightest character, such as doing the washing for the entire family, and carrying it to the top of a three-story house to dry, cooking for boarders as well as for her own family. On the 27th of April, 1873, four o'clock A.M. Sunday morning, I was again called to see her with a similar hemorrhage, just two months and six days after the previous attack. The flow had commenced while she was asleep. When I saw her she was perfectly comfortable, and was losing moderately. She was positive that she was six weeks from her full time, and was certain that she felt the movements of the child. As she had no pain, I gave her directions to be perfectly quiet and keep her bed. I saw her again at nine A.M. She had not changed in any respect; she had no pain, and reassured me that she felt the movements of the child, and that her time was not yet up. I ordered her half-drachm doses of the fluid extract of ergot every hour or two, with directions to send for me at once if there was any increase of the flow. She sent for me at 12 noon; not being in, and no one present realizing the danger, she remained without medical help until I reached her, at half-past one. She

was then exsanguineous, gasping for breath, her pulse flickering. She had bled until there was just enough of blood remaining to keep the heart beating. The tampon was immediately applied, and the little of life that remained was carefully fed with milk, whisky, and air. I watched her and remained with her until four o'clock P.M. At six o'clock she had scarcely reacted any, and was still in a state of syncope, although she had lost not a drop of blood since the application of the tampon. It was not until late in the evening that the pulse became regular and her consciousness restored. She was well fed during the night with whisky, eggs, and milk, and was undoubtedly stronger when I saw her on the morning of the 28th. There was no evidence of hemorrhage externally, and her improvement indicated none internally. At this time Dr. Deal saw her with me, and agreed that it was prudent to gain a little more strength before delivery should be undertaken. The tampon was allowed to remain, but, as there was apparently some distress from tension, it was slightly relaxed. At one o'clock, finding her weaker, Dr. Deal was again called in, and it was agreed that to terminate her labor was the best we could do. The membranes were broken, and delivery accomplished by turning. The placenta came away with the child, and there was no blood accompanying it. The child was dead, and the cuticle over the entire surface of its body came off with the slightest pressure, as if it had been blistered. The womb contracted firmly, and, with the hand kept upon the uterus, and all assistance we could give her, she expired an hour and a half after delivery.

There was no placenta prævia; the bag of waters could be distinctly felt in the mouth of the womb. It was believed to be most likely a detached placenta, and probably brought about by the heavy duties of her household. The first flow two months previous was most likely due to a very slight separation of the placental surface. The child was a full-sized male, and its development had been very recently interrupted.

How was it possible to know before nine o'clock A.M. Sunday morning what ought to have been done? Delivery before that time at the peril of the child might probably have saved her. After the profuse hemorrhage between twelve and one o'clock, there was no time at which delivery promised much. Here was moderate hemorrhage becoming profuse in a few hours. How is it possible for us to know when this change is likely to take place? The treatment of moderate hemorrhage before labor, as laid down by M. P. Dubois, and as given by Cazeaux, is as follows: "Horizontal position, absolute rest, fresh air, cool acidulated drinks, restricted diet, venesection; if there are any symptoms of plethora, empty the bladder and rectum. When the hemorrhage is profuse, the same measures, except venesection, are to be used, with the addition of one-half drachm of ergot, divided in three doses, at intervals of ten minutes. And if these are insufficient, apply the tampon or perforate the membranes."

Can we separate the treatment in this manner? Where can the dividing-line be drawn? From four o'clock A.M. until nine A.M. the flow was undoubtedly moderate; yet within the next three hours it had become profuse. What is best to be done in such cases must of course be left largely to the skill, foresight, and judgment of the physician; and yet might we not arrive at something more definite in the way of treatment?

The treatment of hemorrhages early in gestation,

such as those already referred to as being rarely fatal, is accomplished almost entirely by rest. The gradual enlargement of the vessels, with the increasing size of the uterus, augments the danger with each succeeding month. During the last month, according to Cazeaux, the danger is again diminished, owing to the more easy dilatation of the neck.

THE OPIUM-HABIT.

BY W. D. MARTIN, M.D.,

Pennsylvania Steel-Works.

OPIUM-EATING is seldom spoken of by lecturers in our medical schools. In medical journals, also, the subject is rarely mentioned; and, in consequence of the adroitness of the votaries of opium in concealing a bad habit, the physician in private practice scarcely ever confronts this vice. There are few, therefore, who are familiar with the subject, —one of much importance, now that the use of opium as a stimulant is greatly on the increase in the United States. I have noticed its abuse by physicians, female teachers, servant-girls, and even by farmers' wives.

Seven cases have come under my observation; and I relate the following, a typical case, where, as in the majority of instances, opium was used exclusively as a stimulant:

Early in the year 1867, a gentleman, 28 years of age, in good health, by profession a civil engineer, began the regular use of opium as a stimulant, having for a year before that time merely tampered with it on occasions of despondency and gloom. Engaged in a survey of public lands in remote and lonely situations, his spirits became depressed, and it appeared to him that solitude and misfortune were to be his lot. Under these circumstances he occasionally indulged in alcoholic stimulants, and after a time in such excess as to materially interfere with his duties as an engineer. Realizing this at last, and having read of opium and its extraordinary powers as a stimulant, he had recourse to it when unusually depressed in mind, and finally became habituated to the daily use of the drug.

Beginning with gum-opium, he occasionally rolled up a small piece and swallowed it; but, experiencing unpleasant digestive derangements, pressing constipatory effects, and intense itching of the skin from the use of opium in that form, he employed the salts of morphia. He carried the *sulphate* in a little vial, and used from time to time the indefinite quantity he found necessary to calm his perturbed mind: thus he became addicted to a stimulant, the abuse of which finally became indispensable to a comfortable existence.

As an antidote to whisky he found it perfect. It soon ceased to disturb digestion; it did not flush his face or proclaim itself on the breath; his bowels, though constipated, appeared conveniently so, as he was not bothered with their evacuation more than twice a week, and he could comfortably retain his urine for twenty-four hours. His muscular system was steady, he slept well, his mind was calm and satisfied under all circumstances, and he experienced a strange and agreeable buoyancy, a self-reliance, and a nonchalant happiness all the time.

When I first saw him he had used morphia for four years, had experienced its pernicious effects, and had made several attempts to abandon the habit. At this time he found that, notwithstanding a considerable retrenchment of his daily allowance, he was using eight

grains of the sulphate of morphia per diem, or one drachm per week.

He was sallow, with hands without moisture, and his finger-nails were brittle, his eyes were dull, his mouth and lips dry, the secretions were scanty, the bowels constipated, and he was occasionally subject to temporary, but distressing, bilious diarrhoea. In addition to this, his hair was dry and husky, the skin inactive and itchy, and he had inveterate pityriasis of the scalp.

In disposition he was inert, lazy, forgetful, disposed to sleep, which was uncertain and troubled by dreams, in which he started up in bed, his mind a prey to vague terrors. On this account he often used chloral at night, which, though it produced sleep, exacted an equal number of nights of wakefulness when he discontinued its use. He could not take stimulants for some days after chloral, on account of an intense erythematous blush of the skin which invariably followed, and caused a violent beating of the carotids against his pillow that effectually banished sleep. The sexual function was impaired; and finally he was anxious, nervous, and desirous of freeing himself from the power of opium.

Now, what are we to do for such a case? Diminish very gradually and circumspectly the amount of opium used until the system can do without it? This is quite impracticable, if not impossible, unless the patient is under restraint. Shall we suddenly suspend the poison and sustain the system? This treatment has been employed with success, but it results in great suffering, is also dangerous, and, according to my observation, will not do for bad cases, which are so debilitated after recovery from opium-poisoning that they fall easy victims to pneumonia and kindred affections.

With reference, however, to the train of symptoms to be expected when from any cause opium is suddenly withheld from a person accustomed to its use, I quote from Dr. Flemming, of Birmingham, England, whose method of treatment I have followed, and who treated his cases by suddenly suspending the drug, as recommended by Dr. Christison in 1850:

"Having put a stop to the indulgence, you must be prepared for a great increase in the mental as well as in the bodily suffering of the patient. He is a prey to intense depression; he is sleepless, excessively irritable, full of alarms as to his condition, and will—unless he be a man of unusual strength of mind—pitifully implore you to allow him an opiate to relieve his distress, declaring, if refused, that his life is in danger. At the same time he suffers much from pains in various parts of the body, but especially in the stomach and bowels; the pulse rises much in frequency—I have known it as high as 120; the tongue coated with white fur; there is unceasing thirst, and a total loss of appetite; the bowels, which were formerly confined, are now much relaxed, and a state of diarrhoea is established; the skin softens, and finally sweat pours from the surface."

Under these circumstances Dr. Flemming employs a combination of lupuline with phosphoric acid,—a nauseous dose, but comforting and soothing to the patient; lessening the force of his suffering, and making it tolerable in some cases within a week.

R Acidi phosphorici diluti, ʒx;

Tr. lupulinæ ad ʒxxx.—M.

S.—ʒii every four hours, one hour before food, in a wineglass of water.

With regard to diet, the patient is directed to have at first milk and beef-tea alternately every four hours until the appetite improves, when a stronger diet may be substituted. At night, if wakefulness is protracted, tinct. cannabis ℥xxx with spts. ether is employed with happy effects. In this way the patient and opium may be violently separated, but too often he yields again to its superior power before he can forget its blandishments. The will is too weak, the power of habit too strong.

So far as I am aware, no direct antidote to opium which is powerful enough for a case of this kind is known, but it has always appeared to me that there might be some *substitute* which by combination with other remedies, by a diminution of one and an increase of another, might *insensibly* supplant opium in the system. With this view I have made experiments with different drugs, with nostrums, and with proprietary medicines of several kinds. As the result of my experience, I venture to state finally with regard to some of the latter that the terms I have mentioned appear to be realized. If this is so, the fact is probably familiar to others, who ought to give an opinion on so important a subject.

CASE OF IDIOPATHIC TETANUS SUCCESSFULLY TREATED BY HYDRATE OF CHLORAL AND BROMIDE OF POTASSIUM.

BY W. S. MAXWELL, M.D.

EMMA W., aged four years and six months (colored), was taken on June 20, 1873, with gripping pains in the epigastrium, intense thirst, occasional spasm, and some rigidity about the back. June 23, I was called in. She presented marked symptoms of tetanus: the jaws were partially closed and stiff, deglutition difficult, tongue dry, bowels constipated, trunk and extremities rigid, frequent spasms, breathing short, hurried, and anxious; no fever, pulse natural when quiet.

As to the history of the case, the mother told me that the child had eaten some berries in the woods the day before she was taken, and from her description I supposed them to be berries of the *Atropa belladonna*. The treatment commenced with a laxative, plenty of milk and whisky. Opium, cannabis Indica, quinine, and oil of turpentine were used, but to no purpose; the symptoms grew worse. On July 1 I ordered the following, stopping all other drugs:

Take of Hydrate of chloral,
Bromide of potassium, aa ʒiiss;
Water, ʒii.—Fluid solution.

Label.—Teaspoonful every three hours.

From the first there was marked improvement, and after continuing the remedy for a week the child was cured. She has enjoyed good health since.

STILL POND, MARYLAND.

IODOFORM ON VENEREAL ULCERS (*The Medical Record*, October 15, 1873).—Dr. G. O. Morrison-Fiset adds his testimony to the value of iodoform as a local application to venereal sores. He has found it of great use either in powder or suspended in glycerin.

TRANSLATIONS.

MYELOGENIC LEUCÆMIA.

DR. HUBER, in the *Deutsches Archiv für Klinische Medicin* for October, 1873, reports the following case of leucocythæmia:

The patient, a day-laborer, 43 years of age, came under treatment in October, 1870. His parents died advanced in years, and his only brother had good health. During the preceding eight years the patient had been subject to occasional chilly sensations of short duration, but there was nothing else to warrant the assumption of the existence of intermittent fever. For two years he had been complaining of loss of strength, cough, and dyspnœa. The skin was pale, temperature not increased, pulse regular, tongue clear, appetite and daily evacuations not affected. The lymphatics were not enlarged; legs were œdematous; no abnormal signs in chest; liver not enlarged; the spleen extended to crest of ilium and to the median line.

The urine was pale yellow, with a deposit of triple phosphates and urates. The proportion of red to white blood-corpuscles was ascertained to be two to one.

Death occurred the following January, ushered in by increasing dyspnœa, cough, and repeated epistaxis. The white blood-cells were very large, and some apparently contained yellow pigment-granules. In December he had an attack of pleurisy, with orthopnœa and cough. Urine was then still acid and full of urates. He had also a pustulous exanthem on the chest ten days before death.

The ribs, sternum, and sacrum were found to be full of dirty, greenish-yellow marrow. The spleen was twenty-five centimetres long and twelve centimetres broad, and was dense and resisting, with no attachments. The left pleural cavity was full of serous exudation. In the left ventricle of the heart were found a few drops of blood resembling pus.

Specimens were sent to Prof. Zenker, in Erlangen, who reported that under the microscope the splenic trabeculæ showed an unusually marked and symmetrical development. In the spaces, as in the splenic veins, were found fine spindle-shaped bodies sparsely distributed. These resembled those, unfortunately, still unknown crystals which have been frequently noticed as accompanying leucæmia, and which are by me considered as constant. The marrow of the ribs is strikingly soft and pulpy, is grayish red, and appears to be almost entirely composed of a multitude of medullary cells representing an uncertain transition stage between red and white blood-corpuscles. The crystals referred to existed in greater abundance in the bone-marrow than in the spleen or blood.

FRANK WOODBURY, M.D.

DISLOCATION OF THE SARTORIUS TENDON (*The Lancet*, November 8, 1873).—Mr. Hill reports the remarkable, and probably unique, case of a man, æt. 40, who, while squatting on the floor of a wagon, was fallen upon by a companion whose weight came on his bent knees. When he attempted to rise, the action caused him great pain on extending the leg, especially beyond a certain point. It was found that the sartorius tendon was dislocated backwards by the rupture of its anterior fasciculated expansion. The leg was first flexed until the swelling had subsided, and then put up in a straight back-splint with a foot-piece, a pad being placed over the tendon. At the end of a fortnight the limb was encased in a gum and chalk bandage, and a perfect cure was soon obtained.

RAPID DILATATION OF THE UTERINE ORIFICE (*British Medical Journal*).—Dr. Ellenger, of Stuttgart (*Archiv für Gynaekologie*, vol. v., fasc. 2, 1873), insists enthusiastically on the merits of rapid dilatation of the os and cervix uteri by his instrument. He considers that it ought to supersede sponge-tents, laminaria, and all other methods of slower dilatation. His instrument is based upon those of Perrève and Holt, used in rapid dilatation of the urethra; partaking, however, of the character of a speculum. The cases which he gives as especially suitable examples of success include examples of stricture of the cervical canal, stenoses associated with uterine flexions and deviations, menorrhagia due to softening of the parenchyma, to hypertrophy, or to uterine tumors, retention of disordered secretions in the cavity of the uterus. In one case, where the patient was suffering with hysteria and retroflexion of the uterus, forced dilatation cured a very obstinate neuralgia of the trifacial nerve.

VEHICLE FOR THE ADMINISTRATION OF CHLOROFORM.—A French medical journal remarks that the best course is to dissolve the chloroform in glycerin (1:3), which is effected with tolerable facility, and gives a very clear solution, pleasant to the taste, and with a strong odor of chloroform. This solution can be mixed in all proportions with water without the occurrence of any precipitation, though the odor is distinctly perceptible. In forming the mixture, it is well to add the chloroform slowly and to mingle the two thoroughly. It should be left at rest for twenty-four hours; at the expiration of this period a portion of the chloroform will be found to have collected at the bottom of the vase; this should be separated and mixed with an additional part of glycerin, when no further separation will occur. This mixture may be kept for some time without any loss of chloroform by evaporation.—*Boston Journal of Chemistry*.

NITRITE OF AMYL IN SPASMODIC ASTHMA AND ACUTE BRONCHITIS (*American Journal of Insanity*, October, 1873).—Dr. Daniel H. Kitchen has employed nitrite of amyl with great success in the paroxysmal cough and dyspnœa of acute bronchitis, and in the suffocative attacks of spasmodic asthma. He gives it by inhalation, in doses of from six to fifteen drops, poured into a small cup-sponge and applied immediately to the nose, the mouth being kept shut. He believes its beneficial effect to be due partly to its sedative action on the muscular system through the motor nerves, and partly to its power of diminishing blood-pressure and causing contraction of the capillaries. He details four cases, in all of which a variety of other remedies had been unsuccessfully tried, and in all of which nitrite of amyl gave prompt and entire relief.

DIAGNOSIS OF SEX OF THE FŒTUS IN UTERO (*The Medical Record*, December 1, 1873).—Dr. Willis E. Ford concludes from an analysis of eighty cases that no indication of the sex of the child can be obtained from the pulsations of the foetal heart, and also that the position of the latter during the last month of utero-gestation is no guide to the presentation. In the majority of cases he found the sex of the child to follow that of the older and more robust parent.

DEATH FROM CHLOROFORM (*British Medical Journal*).—A death from chloroform occurred at Hamilton, in the practice of Dr. Dickinson, in the case of a man to whom the anæsthetic had been administered in order to facilitate the reduction of an old-standing dislocation of the shoulder-joint. The deceased had been a hard drinker. Dr. Dickinson used the venous injection of ammonia without any result. It is reported in the *Australian Medical Journal*, August, 1873.

PHILADELPHIA MEDICAL TIMES.

A WEEKLY JOURNAL OF
MEDICAL AND SURGICAL SCIENCE.

The Philadelphia Medical Times is an independent journal, devoted to no ends or interests whatever but those common to all who cultivate the science of medicine. Its columns are open to all those who wish to express their views on any subject coming within its legitimate sphere.

We invite contributions, reports of cases, notes and queries, medical news, and whatever may tend to increase the value of our pages.

All communications must bear the name of the sender (whether the name is to be published or not), and should be addressed to Editor Philadelphia Medical Times, care of the Publishers.

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SATURDAY, JANUARY 10, 1874.

EDITORIAL.

THE LYMPHATIC SYSTEM.

TO us, one of the most curious results of recent anatomical investigations is the great extension which has been given to the prescribed boundaries of the lymphatic system. Not many years since, this system was believed to be a well-defined group of large glands and minute ducts; but advancing knowledge has demonstrated that the Peyer's patches of the intestines form a portion of the system; that the spleen in function and in structure is so closely allied to the lymphatics as to give it a place among them; that scattered through the parenchyma of such glands as the liver are minute microscopic cell-clusters, or, possibly, even single cells, whose anatomical structure and physiological functions entitle them to a position among the lymphatics. Very recently, Neumann and his coadjutors and successors have exalted the marrow of the bones into a similar rank, and Recklinghausen, widening still further the borders of this ubiquitous anatomical system by his researches with the nitrate of silver staining, has, seemingly, established that the serous membranes are great lymphatic sacs. His statements have been confirmed by Ludwig, Schweigger-Seidel, Dybkowsky, Dogiel, and Böhn; and, according to the London *Lancet*, Dr. Klein, now of London, has just completed an elaborate memoir upon the serous sacs, which is to form a portion of a great work on the lymphatic system. In this he confirms the views of

Recklinghausen. The following account of this memoir is taken from the number of the London *Lancet* for December 13:

"The chief points of novelty and interest in Dr. Klein's treatise, which is enriched by ten plates containing many beautiful and original drawings, are, first, that the endothelium of the free surface of the omentum, centrum tendineum of the diaphragm, and pleura mediastini does not everywhere present the well-known flat, tessellated character; but that in many places there are groups of polyhedral, club-shaped, and even short columnar cells, with granular contents, ovoid nucleus, and bright nucleolus. This peculiar form of epithelium Dr. Klein terms 'germinating epithelium,' because numbers of spheroidal cells may be seen in the act of separating or actually detached, which in all respects resemble lymph-corpuscles. The lymph-cells thus lying free in the interior of the great serous sacs make their way into the lymphatic system through small openings distributed over the membrane, bounded by peculiar cells, which instantly call to mind the *stomata* of plants, and to which the same name has been given. In the female frog many of the cells present the peculiarity of being ciliated, and they have been observed to perform amœboid movements. In the next place, Dr. Klein describes the cellular elements of the *matrix* of the serous membranes. These he represents as forming tracts, patches, or nodules by the accumulation of more or less flattened and branched cells, each lying in a cavity of the matrix but little larger than itself; the cavities communicate by passages, and contain, besides the above-named cells, lymph-corpuscles; the whole corresponding to Recklinghausen's lymph canalicular system. These, being outside the true lymphatic vessels, though in close relation with their walls, he terms perilymphangial nodules and tracts. In some parts a still higher grade of organization is reached, the cells developing within lymphatic vessels, and the matrix becoming a reticulum, and containing numerous lymphoid corpuscles, so as to form a kind of adenoid tissue, as Dr. Sanderson has elsewhere described. Finally, in the highest form or stage of development, the nodules become vascularized, the matrix consisting of a reticulum of large branched cells, the spaces of which are filled with fluid or a limited number of lymphoid corpuscles. Both the last forms of tissue he terms endolymphangial tracts or nodules.

"Thus it is seen that just as in hydrocephalus the structure of the brain is unravelled by the accumulation of fluid, so in the serous membrane we have a lymphatic gland opened out to our view. In one part the free surface is found to be covered with germinating cells, which develop into lymphoid or white blood-corpuscles; in another are structures—the perilymphangial nodules—closely resembling the cortical portion of the ordinary lymphatic glands; and in yet another, the endolymphangial tracts and nodules are vascularized structures identical with the medullary portion of the lymphatic glands. In all, the production of lymphoid

corpuscles takes place actively; and the whole may therefore be regarded as ministering to the production and development of blood."

WE desire to call attention to the circular published under the heading of *Notes and Queries*. No words of ours can add force to its statements; and we therefore content ourselves with warmly commending its object to our readers.

CORRESPONDENCE.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

IN the report of the Philadelphia County Medical Society in your issue of the 20th, the reporter quotes me incorrectly.

I not only saw smallpox in the "Neck," but also lost one case of the malignant type. In view of the surroundings, I was surprised at the paucity of cases occurring in that locality. So impressed was I by the probability of a rapid spread of the epidemic among these people, that I addressed a note to the Board of Health, urging their immediate attention to the disinfection of the contents of the wells before the conveyance of the "night-soil" to the truck farms.

In the hurry of my work I have been compelled to neglect my reading, and thus failed to notice this incorrect report.

Truly, etc.,

W. B. ATKINSON.

1400 PINE STREET, Dec. 27, 1873.

PROCEEDINGS OF SOCIETIES.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

DR. W. B. ATKINSON, PRESIDENT, in the chair.

A CONVERSATIONAL meeting was held at the hall of the College of Physicians, Wednesday, November 26, 1873, at 8 o'clock P.M.

A CASE OF EXTRA-UTERINE PREGNANCY—THE CHILD DELIVERED BY GASTROTOMY.

Dr. WASHINGTON L. ATLEE narrated the following interesting case: He had visited Mrs. O'D., of Linwood, Delaware County, in consultation with Dr. Cardeza, November 19, 1873. She was 28 years of age. Menstruation had commenced at the age of 17, and nothing unusual had occurred with regard to this function before marriage, except that during an attack of anæmia it was suspended for about three months. She was married January 12, 1871, and in the month of August following she had a miscarriage in the third month, caused by over-exertion. During this pregnancy she had no nausea or other trouble, and afterwards enjoyed her usual good health.

December 14, 1872, she menstruated for the last time. This was followed by the middle of January, 1873, with great irritability of stomach. The nausea and vomiting were troublesome until the sixth month, after which they diminished somewhat. She ate but little, and

became much reduced. The abdomen gradually became fuller, and she first felt motion in the early part of May, 1873, which subsequently became so well marked that her husband noticed it. The breasts increased in size, the nipples and follicles enlarged, the areolæ deepened in color, and milk could be pressed out. These signs of pregnancy became more and more developed until the third week of September, when Dr. Cardeza was called on to visit her, and found her suffering with pain resembling that of labor. Upon examination, however, he found the neck of the uterus not obliterated,—in fact, very little different from the natural condition. Believing that she had made a mistake in her calculation, he gave an anodyne and left her. Soon after, all fetal movements ceased. Dr. Cardeza was again called on a fortnight afterwards, and the patient was again apparently in labor, there being also a colored discharge from the vagina. The uterus presenting the same conditions as before, he suspected an extra-uterine pregnancy. The discharge referred to commenced October 1, was of a pale-red color, continued about three weeks, then ceased, and again returned for two days, after which it did not recur.

When Dr. Atlee saw her on the 19th of November she was in a state of great emaciation and prostration, with a pulse exceedingly feeble, frequent, and small; tongue red; the stomach rejected everything; the face was pallid, and the eyes were sunken; the body threw off a cadaveric odor; and all the symptoms indicated a state of profound septicæmia.

The abdomen was larger, much more prominent, and narrower than that usual in a woman at full term. It was elastic, and distinctly fluctuating. When pressed suddenly with the finger-points so as to displace the fluid, solid masses could be struck within, and these masses could be put in motion as if submerged in a fluid. The uterus was *in situ*; the os and cervix were patulous, and admitted the index-finger fully one and a half inches. The sound entered three and a half inches, and after having been introduced about two inches appeared to encounter a brittle substance, through which it seemed to tear its way. In front of the uterus a bulging elastic mass could be felt occupying the superior strait.

After making this examination, Dr. Atlee confirmed the diagnosis of Dr. Cardeza. In palpating the abdominal wall, Dr. Atlee noticed that the hypogastric region was much more dense than any other portion, and from this circumstance inferred that this was the point of attachment of the placenta.

In order to afford immediate and temporary relief, the patient was tapped through the linea alba, and seven pints of fetid, purulent fluid were removed; afterwards the form of a child, lying transversely, was readily traceable through the relaxed walls of the abdomen.

The family were advised of the extreme condition of the patient, and that the only hope of life depended on the removal of the dead child; and, under present circumstances, that chance was extremely remote.

The patient having survived a few days, Dr. Atlee was sent for again, and visited her November 24 for the purpose of performing gastrotomy. On entering the house he was met by the exclamation, "Doctor, I fear you are too late; she is dying." Her pulse was over 140, and very feeble; the eyes were staring, the pupils dilated, the abdomen was tympanitic, the mind dull, and she seemed almost in *articulo mortis*.

After stimulating her with brandy, and administering an anæsthetic, an incision about five inches in length was made in the linea alba from the umbilicus downwards through the thin walls of the abdomen, and directly into the cyst enclosing the child. So soon as the latter was opened, there was a rush of very offensive gas, followed by an escape of dirty fluid, containing

portions of dead matter, and also a loop of the umbilical cord. The child was lying crosswise,—the head towards the left side, with the abdomen forward. The feet were seized and the child extracted. It was a female, and was full grown. The placenta, which was attached to the abdominal wall in the hypogastric region, was peeled off by the fingers. It was pretty strongly attached. The sac enclosing the child was decomposed, and, as it protected the viscera from the air and constituted a cavity in itself, it was not disturbed. After cleansing it out with sponges wet with Monsel's solution, the cavity was loosely tamponed with ribbons of muslin moistened by the same solution, and the opening was closed by four sutures, allowing the ends of the tampon to escape from the lower end of the wound.

It was almost a bloodless operation. The section through the abdominal wall was not unlike an incision through the same parts of a body recently deceased, and the separation of the placenta was unaccompanied by bleeding.

Dr. ATLEE was assisted by Drs. Cardeza of Claymont, Drysdale and W. Lemuel Atlee of Philadelphia, and Forward of Chester.

The patient sustained the operation better than was anticipated. She did not lose strength; her pulse rose to 152, but was not more feeble; her voice was stronger, and her mind was clearer.

Dr. ATLEE remarked that the history of this case was peculiar, inasmuch as there were no hypogastric, colicky pains, and no sanguinolent discharge, during the first half of the period of gestation.

Dr. WELCH asked the doctor what anæsthetic was used.

Dr. ATLEE, in reply to Dr. Welch, said that he had used his usual mixture of two parts by weight of ether and one part of chloroform.

Dr. STETLER asked whether the physician in attendance was aware at nine months of her true condition.

Dr. ATLEE answered that when Dr. Cardeza was first summoned, on making an examination he found the cervix uteri intact, and supposed that the patient had made a mistake in her calculation.

Dr. ESHLEMAN asked Dr. Atlee what other attachments there were besides that of the placenta to the abdominal wall.

Dr. ATLEE answered that the membranes were attached to the surrounding parts, and constituted the cyst which enclosed the child. They were allowed to remain. This plan was adopted in a case on which Dr. Atlee successfully operated several years ago,—a patient of Dr. Hinkle. (See his book on the "Diagnosis of Ovarian Tumors," p. 194.)

Dr. HAMILTON thought the case of Dr. Atlee a remarkable one, in that the patient survived the operation; and inquired as to the amount of hemorrhage.

Dr. ATLEE remarked that there seemed to be a check to the capillary circulation, as there was no bleeding. He could understand how, in such a poisoned condition of the blood, passive hemorrhage might occur, or, should reaction come on, how bleeding might follow. For this reason he had used the styptic tampon to guard against it. He had employed Monsel's solution, both as a hæmostatic and an antiseptic.

Dr. KERR asked if there was any hemorrhage after the removal of the placenta.

Dr. ATLEE said there was none.

Dr. O'HARA inquired of Dr. Atlee if there had been a discharge or any symptoms whatever at the third month of pregnancy, and what was the diagnostic value of those symptoms.

Dr. ATLEE, in reply, said there was in this case no sanguinolent discharge in the earlier period of pregnancy. When it did occur, it was due to the separation

of the membrana decidua at that time. An intra-uterine decidua is formed in extra-uterine pregnancy. In this case the exfoliation and extrusion of the decidua had not occurred during the nine months of gestation, as proved by the examination with the sound, and hence there was no bloody discharge during that period.

Dr. WILLIAM GOODELL had seen a very analogous case, in which he made two humiliating errors of diagnosis. It occurred in the practice of Dr. W. C. Perkins, who published an account of it (*Philadelphia Medical Times*, March, 1872, p. 223, and *American Journal of Obstetrics*, vol. v. p. 155).

In this case Dr. Goodell wished to deliver the woman by an incision through the posterior wall of the vagina, but was overruled by her friends. He therefore tapped the womb through the vagina, and drew off clear undecomposed liquor amnii, with great relief to the patient. But she was at that time very low from acute anæmia, and died three days after. At the autopsy a fully-developed child was found within a very large central cyst. When an extra-uterine pregnancy goes to term, he believed it to be always ventral, and never tubal. In tubal pregnancy the cyst ruptures early, and the woman usually perishes from hemorrhage. Whatever the seat of an extra-uterine foetation, a decidual membrane invariably forms. If this is cast off whole, as in his case, the physician is very likely to mistake it for the product of an abortion, and thus lose his bearings. It was the presence of this membrane which had obstructed the passage of Dr. Atlee's sound. Whenever the womb is drawn up by its attachment to the growing cyst, and the cervix is consequently found high above the symphysis, the resemblance to a retroverted gravid womb is so striking that many excellent observers have been deceived. The great danger in a delivery by gastrotomy is hemorrhage from the placental site, for the blood-vessels are not there, as in the womb, constricted by muscular tissue. In view of this danger, recent writers have advised that in ventral foetation the placenta should be left to become spontaneously detached, and that in the tubal the whole cyst should be removed *en masse*.

Dr. O'HARA asked Dr. Atlee what would be the proper time to interfere, providing extra-uterine foetation was recognized, and what interference was necessary in the different varieties.

Dr. ATLEE replied that the rule is for tubal pregnancies to result in rupture before the expiration of the third month, and death occurs from hemorrhage into the peritoneal cavity. In ovarian and ovaro-tubal pregnancies such an occurrence is unusual, unless from violence or accident. In case of rupture of the cyst of either a tubal or an ovarian pregnancy, the abdomen should be opened without delay, and the cavity cleared of all foreign contents.

Dr. LEE asked Dr. Atlee whether he would wait until full term if a ventral pregnancy were previously discovered.

Dr. ATLEE said that unless circumstances called for the operation of gastro-tomy before, he would regard the approach to the full period of pregnancy as the proper time to interfere, where both mother and child might be saved.

Dr. ESHLEMAN inquired of Dr. Atlee whether, in removing the placenta from the abdominal wall, he did not have to contend with profuse hemorrhage, as there could be no such contraction as occurs in the uterus to close the bleeding sinuses.

Dr. ATLEE remarked that in his case there was no hemorrhage from the placenta, but under different circumstances this was to be expected. In all cases of gastrotomy for the removal of an extra-uterine foetus, he would recommend, where there was trouble from

bleeding, compression of the abdominal aorta until the bleeding was controlled by appropriate styptics. The doctor said he had heard nothing from the patient up to this time.

He has since received a letter from Dr. Cardeza, saying that "she gradually sank from pyæmic poisoning forty-six hours after the operation."

Dr. ESHLEMAN related a case of *concealed hemorrhage* in connection with detached placenta at seven and a half months' gestation. The lady, from no assignable cause, suddenly felt a very distressing pressure across the pit of the stomach, and observed a corresponding swelling arise. Upon attempting to use the chamber, a gush of bloody serum half filled the vessel. He found the neck taken up, and was able to press his finger within the os and touch the head, which was pressing firmly against it. The womb felt thick and spongy, as in placenta prævia, so that the question arose at the time whether such could be the case and the placenta have been thrust aside by the child's head under the unremitting pressure. No excessive hemorrhage continued. The mother, who had given birth to several children, insisted that she had no pains. This constant pressure, aided, perhaps, by ergot, slowly opened the os, ruptured the membranes, and in twenty hours from the first symptoms pressed the dead fetus from the mother. The case, thus carefully watched and left to nature, was attended with no very unusual hemorrhage.

The child, before labor very active, ceased to move after the first hemorrhage. It was pale and shrivelled. The cuticle detached with pressure. The placenta was removed from the uterus, and found covered on its maternal surface with firm, dark, coagulated blood, and was rather soft in texture. Its removal was in the course of thirty seconds followed by a firm, dark-colored clot of blood the size of a child's head. The mother made a good recovery.

Dr. GOODELL expressed the opinion that this case was one of concealed accidental hemorrhage. In other words, the placenta had become centrally detached, and blood had escaped into the cup-like cavity thus formed. Some years ago, his attention had been directed to this subject by the loss of a patient from this cause. He then collected and reported over one hundred examples of this very fatal accident (*American Journal of Obstetrics*, vol. ii. p. 281). The graphic description of Dr. Eshleman's, that the child did not appear to be delivered by labor-pains, but "to be pushed slowly out like forced-meat of a sausage-machine," was typical of this kind of hemorrhage. The acute distention of the womb by the effused blood prevented anything like true labor-pains, but it, notwithstanding, developed a very powerful *vis a tergo*. The remedy here was early rupture of the membranes and a rapid delivery by version or by the forceps.

Dr. H. LEAMAN then read a paper on "Accidental Hemorrhage during Pregnancy."

Dr. ESHLEMAN asked Dr. Leaman whether there was any evidence of concealed hemorrhage occasioned by the tampon, as there is some difference of opinion as to its use.

Dr. LEAMAN said there were no evidences of concealed hemorrhage; the bleeding ceased entirely under the use of the tampon, and the patient reacted with the help of stimulants.

Dr. GOODELL said, in the case of frank accidental hemorrhage narrated by Dr. Leaman, that, while appreciating the very embarrassing position in which the doctor was placed, a position which disarmed all criticism, he yet thought it would perhaps have been the better plan to perforate the membranes. The bleeding area would thus have been materially contracted, with a probable arrest of the hemorrhage. In case of failure,

the forceps or version could afterwards be resorted to. He then related the history of a case of post-partum hemorrhage from a lacerated cervix, in which he had finally to tampon with a sponge saturated with Monsel's solution. A strip of the cervix hung down like a ribbon, and the bleeding was so free that he did not dare to remove the tampon before the lapse of forty-eight hours. The decomposition of the retained clots set up a slight attack of septicæmia, but the patient did well upon their removal.

Dr. O'HARA asked if there was serious hemorrhage to be feared in a case of lacerated perineum. He had never seen much loss in these cases, but had heard of a case in which the practitioner was undecided whether it was from the womb or laceration.

Dr. GOODELL said that hemorrhage from a ruptured perineum was sometimes very profuse. He had, in fact, been present at a forceps-delivery in which firm packing of the wound with styptics was needed. The immediate closure of the rupture with silver-wire sutures would have been the proper treatment, but neither he nor the attending physician had their pocket-cases with them. With regard to secondary operations, he had not thus far failed to get an excellent union of the parts. In primary operations he could recall but one failure, and that in a craniotomy case, in which, after the delivery of the head upon very powerful traction, the sudden release of the shoulders tore the perineum quite down to the sphincter ani. On the third day puerperal mania set in, and the patient, by repeatedly jumping out of bed, and by struggling to throw herself out of the window, tore out all the stitches he had put in.

Dr. ESHLEMAN said he had seen profuse hemorrhage from a moderate rupture, but found it ceased when the sutures were applied.

Dr. WELCH related a case which he said possessed other interesting features besides that of hemorrhage occurring previous to delivery. The case was as follows. He was called some years since, in consultation with Dr. Hinkle, to visit Mrs. L., aged 40 years, in labor at the seventh month of gestation. She had been pregnant seventeen times. Eleven children were born at term, and six miscarried. The patient was found suffering from uterine hemorrhage, which had continued for one month. The hemorrhage was not sudden, or gush-like, but of a slow, continual, draining character, which had reduced the patient to a pallid, feeble condition. By examination, Dr. Hinkle found the os tolerably well dilated, and the face of the child presenting, with the chin towards the symphysis. This presentation was readily converted into an occipital, and the forceps were applied; but on making traction they slipped off. It was then learned by digital examination that the child had been dead for a considerable length of time, and that decomposition had taken place to such an extent that the cranial bones had given way at their sutures under the pressure of the forceps. The decomposition was so marked that Dr. Welch was able to perform craniotomy with his index-finger; and, after extracting as many of the bones as possible, he succeeded in delivering the child by winding the scalp around his fingers, with little or no assistance by uterine contraction, although ergot had been freely administered. The placenta, which was found detached, was immediately delivered, but no contraction of the uterus followed. The blood continued to flow, now more profusely than before, and the patient by this time was without any perceptible pulse at the wrist, and was almost reduced to an exsanguineous state. Indeed, so feeble was she that she could only utter monosyllables in a whispering tone. Finding that ergot had failed to act, ice was next used: a small piece was carried well up into the cavity of the uterus, which also failed to produce contraction. Observing that the patient appeared un-

conscious of the presence of the ice in the cavity of the uterus, the question was asked, "Do you feel that?" She replied, with surprise, in a whispering tone, "Feel what?" It was evident that the ice was doing no good, and that it should no longer be relied upon. Vinegar was next used, and with a very decided result; for when the rag saturated with vinegar had just barely reached the cavity of the uterus, the patient shrieked with pain, the uterus contracted violently, the hemorrhage ceased, and a speedy recovery followed. The cause of the accidental hemorrhage was doubtless due to a partial detachment of the placenta, which the patient accounted for by a slight fall on the stairs a few days before the appearance of the bloody discharge. The most interesting feature in this case is not the accidental hemorrhage occurring before delivery, but the prompt and speedy arrest of the post-partum hemorrhage by the use of vinegar.

GLEANINGS FROM OUR EXCHANGES.

INCONTINENCE OF URINE AFTER LABOR (*British Medical Journal*, December 6, 1873).—Mr. Golding Bird reports the case of a woman, aged 32, who suffered from incontinence of urine as the result of a tedious and prolonged labor, in which forceps were applied. The escape of urine was constant; she was mentally depressed, and experienced much pain. The absence of any vaginal fistula was proved by injecting the bladder with colored water, none of which returned by the vagina. On examination per vaginam, there was found plastic effusion around the urethra, the base of the bladder, and lower part of the uterus, fixing the parts completely, so that the sphincter vesicæ was prevented from closing. The bladder was very irritable, much contracted, and could only contain an ounce of urine, and that with much distress. This condition was treated by injecting the viscus with one to two grains of morphia in about half an ounce of water, the operation being preceded by a slightly forcible injection of water to increase mechanically the capacity of the organ. After this was done, the water was allowed to flow, and the morphia, being injected, was retained as long as possible. The quantity used for distention depended on the distress produced: it was never carried beyond slight pain. By these means the bladder was enabled to hold first two, then three ounces; and, as the cellulitic deposit became absorbed and the power of the sphincter increased, she was able to hold fluid better, until in about three weeks she could voluntarily retain her urine for half an hour.

The thickening gradually passed off, and in six weeks—when she passed from under observation—the bladder could hold eight ounces.

ATROPIA IN PHTHISICAL SWEATING (*British Medical Journal*, November 29, 1873).—A notice in the *Philadelphia Medical Times* of last year, in which Dr. J. C. Wilson stated that he had successfully used sulphate of atropia in doses of one-eightieth of a grain for the relief of profuse sweating in four cases of phthisis, led Dr. Fräntzel to make an extended series of researches in the Charité Hospital in Berlin on the effect of atropia in such cases. In a paper on the subject published in *Virchow's Archiv*, vol. lxxviii. part i. (*Allgemeine Medicin. Central-Zeitung*, August 2), he states that, having given it to seventy-five cases, he has arrived at the conclusion that it is a remedy that he can confidently recommend not only in phthysical sweating, but also in that which attends other diseased conditions, such as acute articular rheumatism and convalescence from trichinosis. Among the seventy-five cases were fifteen

cases of more or less recent cheesy pneumonia, of whom all had more or less fever with night-sweats; forty-eight of distinct pulmonary phthisis, of whom forty-two had hectic; one of acute articular rheumatism with high fever; two of ulcerative endocarditis, and two of trichinosis. In the first fifteen patients the sweating was in six completely arrested, in seven much diminished, in two there was no change. In the forty-eight phthysical cases, the medicine had no effect in five, in twenty-one the sweating was remarkably abated, and in twenty-two it disappeared entirely. Several of the patients in whom the atropia failed were near death when it was given. In the eight cases of rheumatism the atropia gave permanent relief in five, in two it produced a marked diminution of the sweats, in one it was useless. In one of the cases of ulcerative endocarditis it proved useful; not so in the other. In the two cases of trichinosis the cessation of the acute stage of the disease, and of the hectic fever attending it, was followed without any rise of temperature by profuse night-sweats. Sulphate of atropia, in doses of a milligramme (.015 grain), was given two hours before the expected access of sweating daily for five days in succession in one case, and for three days in the other; the result being that the sweats entirely disappeared from the first evening when it was given. In one of the cases of rheumatism, in a man aged thirty-two, nearly all the large joints of the upper and lower limbs had been severely affected during five days; the patient was covered with sudamina, and, when seen by Dr. Fräntzel, was bathed in sweat. A milligramme of sulphate of atropia was given immediately, and very soon there was an abatement of the sweating, which in two hours disappeared. It returned in the night, but ceased the next forenoon after the administration of a similar dose. The atropia was thenceforth given regularly night and morning, with the effect of completely preventing the sweating. The fever lasted fourteen days. In another case of acute articular rheumatism, atropia was given first in doses of one, then of two milligrammes, with a similar result; and it is remarked that on two days in the course of the disease in which it was omitted, the sweating recurred. The atropia was given according to the following formula: sulphate of atropia, six milligrammes (9-100ths of a grain); extract of gentian, sufficient to make ten pills. Dr. Fräntzel has never given larger doses than 1.2 milligrammes (a little less than one-fiftieth of a grain), from fear of producing toxic symptoms. Even doses of 0.6 and 1.2 milligrammes, though unattended with any mischief, have produced slight symptoms of poisoning. In not a few cases after taking the medicine, the patient felt itching in the neck, which, however, disappeared in one or two hours. The pupils not unfrequently acted slowly, and were sometimes dilated. In some cases there were muscæ volitantes. The atropia had to be stopped in four cases on account of diarrhœa: that this was due to the medicine was proved by the fact that it ceased when the atropia was discontinued, and reappeared when it was resumed. What the physiological action of atropia is in arresting perspiration, Dr. Fräntzel says it is difficult to determine. He is, however, inclined to believe that the profuse sweats arise from relaxation of the walls of the vessels supplied to the sudoriferous glands; and he remarks that the researches of Meuriot, Fleming, Jones, Hayden, and Brown-Séquard have shown that atropia contracts the smallest vessels. To this are to be ascribed both the diminution of the sweats and the dryness of the mouth and skin observed in cases of poisoning with belladonna and with atropia.

SUPPRESSION OF URINE (*British Medical Journal*, November 22, 1873).—Mr. Albert Kisch reports the case of a female, æt. 47, who, when he first saw her, had not

passed urine for eleven days. There was nothing in her countenance or general aspect to arrest attention, but the tongue was exceedingly anæmic and slightly coated at the back, and there was a continual sense of nausea. She had vomited once on the preceding day. She had been subject to diarrhoea for some years, and to continual drowsiness, which often passed into sleep with heavy snoring; she had frequently suffered from aching in the back; the urine, which was never very copious, had been somewhat reduced for two months, and there had been some puffiness about the lower eyelids.

A catheter was passed, but not a drop of urine escaped. The bowels having been freely relieved by saline cathartics, she was then treated by dry cupping in the loins, fomentations of digitalis over the abdomen, and infusion of digitalis internally. She was placed on a diet of water and skimmed milk, *ad libitum*, with a little bread and beef-tea.

About noon on the following day she passed three drachms of very turbid urine, albuminous, crowded with blood-disks and epithelial cells from the genito-urinary tract, and exhibiting a few epithelial casts. Two hours later she passed urine freely; it was pale, clear, feebly albuminous, with a few casts, but free from blood-disks. Early in the next day she had a severe convulsive seizure, which was succeeded by others with varying frequency until her death, which occurred two days later. The case is interesting from the long and almost absolute suppression of urine without anasarca or other prominent symptoms, and from the occurrence of convulsions subsequent to the free passage of urine. The latter must have been the product of the excreting and not the secreting part of the kidneys, and was clearly nothing more than the *urina potius*, due to the copious liquid diet. No necropsy was permitted, but the kidneys were probably small and granular, and diseased to such a degree that the whole of the cortical and the greater part of the medullary portion had ceased to act.

HYPODERMIC INJECTIONS IN THE TREATMENT OF CHOLERA (*Indian Medical Gazette*, November 1, 1873).

—Surgeon A. R. Hall believes that in the collapse of cholera the patient is not suffering from nervous exhaustion, but is being suffocated by spasmodic contraction of the muscular coats of the arteries, due to the same cause as the vomiting and purging,—a specific irritation of the medulla oblongata and sympathetic nerve. Proceeding on this theory, he has treated his last case of cholera by subcutaneous injections of chloral hydrate, which he asserts to be one of the most powerful cardiac sedatives we possess. The patient when first seen was in a state of collapse, had the regular choleraic voice, fingers blue and wrinkled, and pulse barely perceptible at the wrist, although the heart was beating strongly; there were frequent vomiting and purging, cold skin and breath, shrunken eyes, and cramps in the legs; he had not passed urine for several hours. One scruple of chloral was given by the mouth, but was immediately rejected. Five grains of chloral in solution in fifty minims of water were then injected under the skin of the arm. His hands and feet soon became warmer, and his radial pulse more perceptible. In about two hours vomiting and purging increased, and his hands grew colder; two and a half grains additional were injected, and two hours later the same quantity again. In a short time the vomiting subsided, the temperature rose, and he passed a small quantity of highly albuminous urine. He steadily improved, was well fed for a few days, and made a rapid recovery. Three other cases treated similarly by another practitioner all resulted equally favorably.

A correspondent of *Le Progrès Médical*, November 22, advocates the hypodermic injection of sulphuric ether and other stimulants in adynamic cases, and

mentions one in which the injection of from two to three grammes of pure ether was the means of bringing a patient through the algid stage of cholera after all other remedies had failed.

THE DETECTION OF STONE (*British Medical Journal*, December 6).—At a recent meeting of surgeons at the Medical Society, Mr. W. D. Napier described his instruments for the detection and removal of stone in the bladder. The diagnostic properties of the sound or "detector" invented by this gentleman depend on its beak being coated with lead, and on the soft and polished surface thus obtained becoming scratched by the slightest contact with any hard substance. If the calculus be small, or if fragments remain after crushing operations, recourse must now be had to the second instrument, which consists of an india-rubber tube, with expanded extremity, not unlike an ordinary convolvulus. Introduced in a folded condition through a species of catheter tipped with cacao-butter, the removal of the canula permits the full opening-out of the cup, which acts as a species of wing in retaining the instrument towards the neck of the bladder. The force of gravitation now inclines any foreign body to be drawn within the pliable and elastic walls, and the process of removal may be completed without any fear of injury to the mucous membrane from the sharp edges of fragments. Mr. Napier concluded by an interesting demonstration on a prepared bladder and urethra, and an animated discussion ensued, in which most of the surgeons present took part.

RUPTURE OF THE STOMACH (*British Medical Journal*, November 22, 1873).—Mr. H. Kirwan King was summoned hurriedly to his office, and found a man staggering about, unable to speak, but groaning with acute pain, and both hands pressed firmly into his stomach. He fell down in a state of collapse, and died in a few minutes.

At the post-mortem examination, two enormous clots were found on each side of the spine; and on the anterior surface of the pyloric pouch was an irregular aperture with edges infiltrated with black blood, and presenting appearances of ulceration. The upper portion of the duodenum was distended with clots. The liver was quite healthy; but a roundish gall-stone, about the size of a nut, was firmly impacted in the neck of the gall-bladder. The remaining viscera were quite healthy. The rupture was probably induced by the efforts made to relieve the pain of the gall-stone by violent pressure to the epigastrium; the coats of the stomach, being preternaturally weakened by ulceration, gave way, and the patient died from the shock.

ERGOT IN EPISTAXIS (*The Medical Record*, October 15, 1873).—Dr. Andrew H. Smith reports the case of a man, æt. 37, who suffered from persistent epistaxis, recurring sometimes two or three times a day. Direct and rhinoscopic examination showed no abnormal condition of the nasal mucous membrane. Astringents were applied locally by means of both the brush and syringe, and such general treatment was resorted to as the symptoms demanded. After this had been persevered in for two weeks without affecting the hemorrhages, the fluid extract of ergot was prescribed in twenty-drop doses three times a day.

This was continued for ten days, with the effect of entirely restraining the bleeding from the time the first dose was taken. The medicine was then omitted, but in a few days the bleeding began anew. It was immediately arrested by a resort to the drug, and did not afterwards return; the medicine being continued at gradually-increasing intervals for nearly a month.

INOCULATION OF SYPHILIS IN CIRCUMCISION (*New York Medical Journal*, December, 1873).—Dr. R. W.

Taylor, of New York, in an interesting communication "On the Question of the Transmission of Syphilitic Contagion in the Rite of Circumcision," considers this subject—which is one of importance to the Jews of our population—in a most thorough manner. Four cases of suspected syphilis, supposed to have been acquired in this way, are carefully analyzed, and the results presented.

The conclusions which Dr. Taylor arrives at upon this subject may be summed up briefly as follows: That in the Jewish rite of circumcision there is a possibility of syphilis being acquired; that the contagion is most likely to occur in the act of sucking the wound. Dr. Taylor recommends that the operation of sucking should be wholly abolished, and if a styptic solution of any kind is used it should be poured from a vessel on the wound rather than squirted upon it from the mouth of the operator.

MISCELLANY.

DISEASE-DESTROYING TREE.—M. Gimbert, who has been long engaged in collecting evidence concerning the Australian tree *Eucalyptus globulus*, the growth of which is surprisingly rapid, attaining besides gigantic dimensions, has addressed an interesting communication to the Academy of Sciences. This plant, it now appears, possesses an extraordinary power of destroying miasmatic influence in fever-stricken districts. It has the singular property of absorbing ten times its weight of water from the soil, and of emitting antiseptic camphorous effluvia. When sown in marshy ground it will dry it up in a very short time. The English were the first to try it at the Cape, and within two or three years they completely changed the climatic condition of the unhealthy parts of the colony. A few years later its plantation was undertaken on a large scale in various parts of Algeria. At Pardock, twenty miles from Algiers, a farm situated on the banks of the Hamyze was noted for its extremely pestilential air. In the spring of 1867 about thirteen thousand of the eucalyptus were planted there. In July of the same year—the time when the fever season used to set in—not a single case occurred; yet the trees were not more than nine feet high. Since then complete immunity from fever has been maintained. In the neighborhood of Constantine the farm of Ben Machydlin was equally in bad repute. It was covered with marshes both in winter and in summer. In five years the whole ground was dried up by fourteen thousand of these trees, and farmers and children enjoy excellent health. At the factory of the Gue de Constantine, in three years a plantation of eucalyptus has transformed twelve acres of marshy soil into a magnificent park, whence fever has completely disappeared. In the island of Cuba this and all other paludal diseases are fast disappearing from all the unhealthy districts where this tree has been introduced. A station-house at one of the ends of a railway-viaduct in the Department of the Var was so pestilential that the officials could not be kept there longer than a year. Forty of these trees were planted, and it is now as healthy as any other place on the line. We have no information as to whether this beneficent

tree will grow in other than hot climates. We hope that experiments will be made to determine this point. It would be a good thing to introduce it on the West Coast of Africa.—*Times and Gazette*, Nov. 1, 1873.

A MAN advertises for a competent person to undertake the sale of a new patent medicine, and adds that "it will prove highly lucrative to the undertaker."

NOTES AND QUERIES.

TO THE MEDICAL PROFESSION AT LARGE.

IN obedience to the resolution of the Convention of Physicians, lately assembled in this city, we undertake this address to your sympathy, with full assurance that its hallowed object will secure your cordial support.

But yesterday our community was as a house of mourning, and its wail of distress, arising from stricken hearts and desolate homes, smote the ear of the world with the horrors of our affliction. Those of our people who remained in the doomed city can only appreciate the sad story of suffering seen and felt in our midst, when death thus held, for seven long weeks, its high carnival among us. Over the entire city death and silence brooded. Its deserted streets, alike both day and night, scarce echoed a sound save the mournful hearse-rattle as it hurried to the grave its load of dead, or the footfalls of those ministers of mercy who lighted up the hours of darkness with their visits of charity. Silently and continually the pious labor of love was performed, and each rivalled the other in the patient discharge of a common humanity. When the shaft of death prostrated one, another with true Corsican spirit took his place, and the work of benevolence went fearlessly on, until under the favor of Heaven the disease was baffled and the reign of terror at an end. Each creed, sect, order, and brotherhood had its heroes and its martyrs, and it is in commemoration of the deeds of both the living and the dead that our hearts should never suffer forgetfulness.

The faithful physician who survived the storm bears in his conscience its plaudits of duty done; but our seven brothers, Williams, Freeman, Crone, Hatch, Kennon, Blount, and Minor, fallen at their post, martyrs to the cause of humanity, ay, bright exemplars of professional honor and duty, sleep in their quiet graves, with more lasting glory than embalmed warriors in piles of storied marble. Our fallen brothers, if they could be consulted, would doubtless wish no fitter burial than quiet interment in leafy Elmwood, but professional pride demands the honor of their perpetual commemoration, and we ask in this behalf that suitable stone be raised and carved for them. Their fame, the story of their heroism, belongs to the medical world, and our brethren throughout the broad land are respectfully requested to contribute something to this laudable end. Your contributions, however small, will aggregate a success of the enterprise.

Remittances may be made to either member of the Committee.

RICHARD H. TAYLOR, M.D., 44 North Court Street.

F. L. SIM, M.D., 115½ Beale Street.

R. W. MITCHELL, M.D., 275 Main Street.

MEMPHIS, TENN., November 10, 1873.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Dr. J. Solis Cohen will read a paper before the Society, Wednesday, January 14, at 8 o'clock P.M., on "Croup in its Relations to Tracheotomy."

All regular practitioners of medicine in the city are invited.

THE letter from "Fizic" has been received. The editor of the *Philadelphia Medical Times* is always obliged for any hints or suggestions as to the management of the journal, but would certainly be more affected by the advice if the author had had the backbone to sign his name.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY, FROM DECEMBER 30, 1873, TO JANUARY 5, 1874, INCLUSIVE.

ABADIE, J. H., SURGEON.—Granted leave of absence for four months, on Surgeon's Certificate of Disability. S. O. 1, A.G.O., January 2, 1874.